

Check all box(es) and complete all sections that apply. Return completed form to your Human Resources Department.

MEMBER INFORMATION	Enrollment <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Rehire/Reinstatement		Change <input type="checkbox"/> Beneficiary Change <input type="checkbox"/> Name Change		<input type="checkbox"/> Address Change <input type="checkbox"/> Other _____	
	Group Name City of Riverside		Group Number 641996		Division ID	
	Your Name (Last, First, Middle)		If name change, what was your former name?		Soc. Sec. No.	
	Your Address		City		State	Zip
	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Earnings \$	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr	
	Date of Hire	Hours Worked Per Week		Job Title/Occupation		
	COVERAGE SECTION	<i>Check with your Human Resources Department about coverage options and Evidence Of Insurability requirements.</i> Management employees representing the General Unit, or Public Utilities Field Unit, City Council members, Police Chief & Fire Chief, who participate in the Deferred Compensation Plan <input checked="" type="checkbox"/> Life/AD&D <input type="checkbox"/> Voluntary Long Term Disability – Premiums paid through your Deferred Compensation Plan.				
Members of IBEW Local 47 <input checked="" type="checkbox"/> Life/AD&D <input checked="" type="checkbox"/> Long Term Disability						
All Other Members <input checked="" type="checkbox"/> Life/AD&D						
<i>This designation applies to Life/AD&D coverage. Designations are not valid unless signed, dated, and delivered to the City of Riverside Human Resources Department during your lifetime. See page 2 for further beneficiary information.</i>						
BENEFICIARY	Primary – Full Name		Address		Soc. Sec. No.	Relationship
	Contingent – Full Name		Address		Soc. Sec. No.	Relationship
SIGNATURE	I wish to apply for insurance under the Group Insurance Plan, or to authorize the changes noted above. I authorize deductions from my Deferred Compensation Plan to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.					
	Member Signature Required				Date (Mo/Day/Yr)	

Human Resources Department – Retain for your records.

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
 1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
 2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
 3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.